STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06105-3725

[redacted], 2018
Signature Confirmation

Case ID # [redacted]
CL ID # [redacted]
Request ID [redacted]

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2018, the Department of Social Services (the "Department") issued a Notice of Action ("NOA") to [redacted] (the "Appellant") indicating that the Appellant's Community First Choice ("CFC") Individual Budget amount would be reduced from $42,973.13 to $22,105.44 per year, due to a reduction in Personal Care Assistance ("PCA") service hours from 44 hours to 26.25 hours per week effective [redacted] 2018, based on a reassessment of the Appellant's level of need.

On [redacted] 2018, the Appellant's AREP requested an administrative hearing to contest the Department's to take such action.

On [redacted] 2018, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling an administrative hearing for [redacted] 2018.

At the Appellant's AREP's request, the administrative hearing was rescheduled. On [redacted] 2018, OLCRAH issued a notice scheduling an administrative hearing for [redacted], 2018.

On [redacted] 2018, in accordance with sections 17b-60, 17b-61, and 4-176e to 4-189, inclusive, of the Connecticut General Statutes, the OLCRAH held an administrative hearing.

The following individuals were present at the hearing:

[redacted], Appellant
[redacted] Appellant's AREP and sister
[redacted]
Dawn Lambert, Department's Representative
Sybil Hardy, Hearing Officer

The hearing record remained opened for the Department to review new assessment information. No new information was received from the Department. On [redacted] 2018, the hearing record closed.

STATEMENT OF THE ISSUE

The issue is whether the Department correctly reduced the Appellant's CFC service budget based on the Appellant's current level of need.

FINDINGS OF FACT

1. During [redacted] the Appellant moved into the AREP's home and the AREP began providing personal care services. (AREP's Testimony)

2. On [redacted] 2016, the Department conducted an assessment of the Appellant's level of need and determined that the Appellant required assistance with her activities of daily living ("ADLs") and her instrumental activities of daily living ("IADLs"). The Appellant was also a recipient of the Department of Developmental Services ("DDS") Waiver Program (Hearing Summary, Exhibit 2: CFC Budget Approval and Statement of Goals)

3. On [redacted] 2016, the Department approved the Appellant's service plan of $42,973.13 allowing her to receive 44 Personal Care Attendant ("PCA") services and Workers Compensation premium payments. (Hearing Record, Exhibit 2)

4. On [redacted] 2017, the Department conducted another assessment and made no changes to the Appellant's budget. (Exhibit 2: Connecticut DDS Level of Need Assessment and Screening Tool, [redacted]/2017)

5. The Department redesigned the eligibility for CFC services to meet new federal guidelines and to implement a revised Universal Assessment. The Department contracted with the [redacted] to determine level of care needs and service plan budgets. (Hearing Record)

6. The Department's revised Universal Assessment guidelines standardized the assessment process by linking clinical responses to assessment questions and using clinical criteria to determine the level of care and service needs budgets. (Hearing Summary)

7. On [redacted] 2018, the [redacted] conducted a reassessment of the Appellant's level of need and service plan, and determined that the Appellant needs extensive assistance with bathing, dressing and Toileting. The Appellant needs limited assistance with eating and is independent with transferring. (Hearing Record, Exhibit 7)

8. The Appellant was not given a level of need score or a level of care determination. Because of her intellectual disability and eligibility for the waiver program she was determined categorically eligible for the CFC program. (Department Representative's Testimony, Exhibit 7)

9. The Appellant is 47 years of age [redacted] (Appellant's Testimony)

10. The Appellant has a medical diagnosis of Down Syndrome, Intellectual Disability, chronic constipation, GERD, heart condition, hypothyroid, dental or gum disease, Obsessive-Compulsive Disorder ("OCD") and anxiety. She is alert and oriented. (Hearing Record, Exhibit 6: CT DDS Level of Need Assessment and Screening Tool, [redacted]/18, Exhibit 7: NOA and Universal Assessment, [redacted]18)

11. The Appellant's cognitive status is alert and oriented. (Exhibit 7)

12. The Appellant exhibits disruptive behavior which disrupts or interferes with activities of the person or others, opposes support or assistance, verbal aggression or emotional outbursts, mild physical assault or aggression, self-injurious behavior. (Exhibit 6)

13. The Appellant has tactile kinesthetic issues, a hypersensitivity to touch and others sensory stimulation such as light or sound. (Exhibit 6)

14. The Appellant walks by herself but may require physical support or assistance from another person. (Exhibit 6)

15. The Appellant requires assistance to take medications. (Exhibit 6)

16. The Appellant requires assistance to complete household chores or cannot complete household chores at all. (Exhibit 6)

17. The Appellant requires assistance for meal planning and shopping. (Exhibit 6)

18. The Appellant requires assistance to budget, pay bills, or manager money, or cannot budget or manage money at all. (Exhibit 6)

19. The Appellant lives with the AREP in the home with the AREP who provides all the Appellant's PCA services. (AREP's Testimony)

20. The Appellant receives a grant of $5,900.00 per year which allows another PCA to take the Appellant out for social activities six hours per week. (AREP's Testimony)

21. On [redacted], 2018, the Department issued a NOA to the Appellant informing her that the revised funding appropriate to her level of need was $22,105.44 per year, effective [redacted], 2018, because her PCA hours were reduced to 26.25 hours per week. (Exhibit 7: NOA, [redacted]/18)

22. On [redacted] 2018, at the time of the administrative hearing, the Department discovered that it had made the determination of a reduction in PCA services based on incorrect information that the Appellant was attending a group day program. (Hearing Record)

23. The Department's plan was to review and respond to new information obtained during the administrative hearing on [redacted] 2018 but no response or additional information was received. (Department Representative's Testimony)

24. On [redacted] 2018, the hearing officer requested the results of the assessment review. (Hearing Record)

25. A written review of the Appellant's assessment was not received by the hearing officer. (Hearing Record)

CONCLUSIONS OF LAW

1. The Department is the state agency for the administration of the Medicaid program pursuant to Title XIX of the Social Security Act. The Commissioner may make such regulations as are necessary to administer the medical assistance program. [Conn. Gen. Stat. § 17b-2; Conn. Gen. Stat. § 17b-3]

2. Title 42 of the Code of Federal Regulations ("CFR") § 441.500 (a) provides that this subpart implements section 1915(k) of the Act, referred to as the Community First Choice Option (hereafter Community First Choice), to provide home and community-based attendant services and supports through a State plan.

3. 42 CFR § 441.500 (b) provides Community First Choice is designated to make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision, or cueing.

4. Title 42 CFR § 441.510 provides in part that to receive Community First Choice

services under this section, an individual must meet the following requirements: (a) Be eligible for medical assistance under the State plan; (b) as determined annually: (1) Be in an eligibility group under the State plan that includes nursing facility services; or (2) if in an eligibility group under the State plan that does not include such nursing facility services, have an income that is at or below 150 percent of the Federal poverty level (FPL). In determining whether the 150 percent of the FPL requirement is met, States must apply the same methodologies as would apply under their Medicaid State plan, including the same income disregards in accordance with section 1902(r)(2) of the Act; and (c) Receive a determination, at least annually, that in the absence of the home and community-based attendant services and supports provided under the subpart, the individual would otherwise require the level of care furnished in a hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over, if the cost could be reimbursed under the State plan. d)For purposes of meeting the criterion under paragraph (b) of this section, individuals who qualify for medical assistance under the special home and community-based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act must meet all section 1915(c) requirements and receive at least one home and community-based waiver service per month. (e)Individuals receiving services through Community First Choice will not be precluded from receiving other home and community-based long-term care services and supports through other Medicaid State plan, waiver, grant or demonstration authorities.

5. State Plan Under Title XIX of The Social Security Act states: Community First Choice State Plan Option Pursuant to Section 1915(k) of the Social Security Act provides that:

    1. Eligibility

        A. The State determines eligibility for Community First Choice (CFC) services in the manner prescribed under 42CFR § 441.510. To receive CFC services and supports under this section, an individual must be eligible for medical assistance under the State plan and must be in an eligibility group that includes nursing facility services or must have income below 150% of the Federal Poverty Level (FPL) if they are in an eligibility group that does not include Nursing Facility services.

        Individuals who are receiving medical assistance under the special home and community-based waiver eligibility group defined at section l 902(a)(lO)(A)(ii)(VI) of the Act must continue to meet all 1915(c) requirements and must receive at least one home and community-based waiver service per month. Individuals receiving services through CFC will not be precluded from receiving other home and community-based long-term services and supports through the Medicaid State plan, waiver, grant or demonstration but will not be allowed to receive duplicative services as between CFC and any other

available source of Medicaid coverage for home and community-based services.

6. 42 CFR § 441.535 provides for Assessment of functional need. States must conduct a face-to-face assessment of the individual's needs, strengths, preferences, and goals for the services and supports provided under Community First Choice in accordance with the following:

    (a) States may use one or more processes and techniques to obtain information, including telemedicine, or other information technology medium, in lieu of a face-to-face assessment if the following conditions apply:

        (1) The health care professional(s) performing the assessment meet the provider qualifications defined by the State, including any additional qualifications or training requirements for the operation of required information technology;
        (2) The individual receives appropriate support during the assessment, including the use of any necessary on-site support-staff; and
        (3) The individual is provided the opportunity for an in-person assessment in lieu of one performed via telemedicine.

    (b) Assessment information supports the determination that an individual requires Community First Choice and also supports the development of the person-centered service plan and, if applicable, service budget.

    (c) The assessment of functional need must be conducted at least every 12 months, as needed when the individual's support needs or circumstances change significantly necessitating revisions to the person- centered service plan, and at the request of the individual.

    (d) Other requirements as determined by the Secretary.

    The Department correctly completed as assessment through its contractor to determine a revised CFC Individual Budget, but included information that was incorrect.

7. 42 CFR § 441.505 provides for definitions and states in part that Activities of daily living (ADLs) means basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring. Instrumental activities of daily living (IADLs) means activities related to living independently in the community, including but not limited to, meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.

The Department correctly determined that the Appellant's needs extensive assistance with the following ADL's: bathing, dressing and toileting.

8. Title 42 CFR § 441.540(b)(5) provides that the person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under Community First Choice, the plan must reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports cannot supplant needed paid services unless the natural supports that are provided voluntarily to the individual in lieu of an attendant.

9. Connecticut State Plan Amendment ("SPA") no. 15-012, pursuant to section 1915(k) of the Social Security Act, 5 A provides for limits on amount, duration or scope of included services. It states that the Department assigns an overall budget based on need grouping that is determined by algorithm and that natural supports are based on the individual's functional assessment, which will take into consideration the availability of natural supports. Natural supports are identified during the person centered service planning process and utilized when available to the individual. Natural supports are defined as voluntary unpaid care provided on a regular and consistent basis by a parent, spouse or other person.

The Department incorrectly determined that the Appellant attends a group day program.

Based on the evidence provided for the hearing the hearing officer is unable to make a decision regarding the reduction of services because the Department made their decision based in information that was incorrect. At the time of the hearing the Department indicated they would review this evidence because it could change the Appellant's budget. This information was due back to the Department by [redacted] 2018. No new information or response was received from the Department.

DECISION

The Appellant's appeal is **REMANDED** back to the Department for further action**.**

ORDER

1. The Department is ordered to complete a new assessment and make corrections to the services received by the Appellant.

2. The Department shall provide the Appellant a new revised CFC Individual Budget and issue a signed NOA explaining the any changes.

3. Compliance of this order is due back to the undersigned no later [redacted] 2018.

Sybil Hardy
Hearing Officer

Pc: Dawn Lambert, DSS, Central Office
Kari Echevarria, DSS, Central Office

RIGHT TO REQUEST RECONSIDERATION

The appellant has the right to file a written reconsideration request within **15** days of the mailing date of the decision on the grounds there was an error of fact or law, new evidence has been discovered or other good cause exists. If the request for reconsideration is granted, the appellant will be notified within 25 days of the request date. No response within 25 days means that the request for reconsideration has been denied. The right to request a reconsideration is based on §4-181a (a) of the Connecticut General Statutes.

Reconsideration requests should include specific grounds for the request: for example, indicate what error of fact or law, what new evidence, or what other good cause exists.

Reconsideration requests should be sent to: Department of Social Services, Director, Office of Administrative Hearings and Appeals, 55 Farmington Avenue, Hartford, CT 06105-3725.

RIGHT TO APPEAL

The appellant has the right to appeal this decision to Superior Court within 45 days of the mailing of this decision, or 45 days after the agency denies a petition for reconsideration of this decision, provided that the petition for reconsideration was filed timely with the Department. The right to appeal is based on §4-183 of the Connecticut General Statutes. To appeal, a petition must be filed at Superior Court. A copy of the petition must be served upon the Office of the Attorney General, 55 Elm Street, Hartford, CT 06106 or the Commissioner of the Department of Social Services, 55 Farmington Avenue, Hartford, CT 06105. A copy of the petition must also be served on all parties to the hearing.

The 45 day appeal period may be extended in certain instances if there is good cause. The extension request must be filed with the Commissioner of the Department of Social Services in writing no later than 90 days from the mailing of the decision. Good cause circumstances are evaluated by the Commissioner or the Commissioner's designee in accordance with §17b-61 of the Connecticut General Statutes. The Agency's decision to grant an extension is final and is not subject to review or appeal.

The appeal should be filed with the clerk of the Superior Court in the Judicial District of New Britain or the Judicial District in which the appellant resides.